Name:_____ Date of Birth:_____/_____/_____ Age:_____

First MI Last Social Security #_____/_____/_____

Address:_____

Street Apt # City State Zip

Male/Female Married/Single/Divorced Cell Phone:_____

Home Telephone:_____ Employer Name:_____

E-MAIL ADDRESS:_____ Employer Telephone:_____

Spouse's Name:_____ Daytime Telephone:_____

Spouse's DOB:_____/_____/_____ Spouse's Employer:_____

Spouse's Social Security #_____/_____/_____(only needed if spouse is the insurance policyholder)

PRIMARY INSURANCE:_____ PHONE:_____ we will make a photocopy

SECONDARY INSURANCE:_____ PHONE:_____ we will make a photocopy

In case of emergency, please contact: Name:_____Relationship:_____

Telephone Number:_____

Who is your primary care physician? _____**Phone:**_____

(If you would like a copy of your test results forwarded to your physician, please sign the release below)

Who referred you to our office?

We like to know how our patients find our practice. If your physician, a family member, or a friend sent you in, we want to thank them. If you learned about our office another way, it is helpful that we know. Please check below the MOST influential sources of information about this practice. If it is your physician, an audiologist, family member, or a friend, please provide their name. Thank You!

_____Physician	_____Vocational Rehabilitation	_____Health Plan/HMO
_____Audiologist	_____Yellow Pages	_____Attended Seminar
_____Family Member	_____Newspaper Ad/Article	_____Internet
_____Friend/Co-worker	_____Hospital Referral Service	_____Other:_____

Please provider the name of the person that referred you to our office:_____

In order for us to file your insurance claim for you, the following MUST be signed:

I authorize the release of any medical and/or other information necessary to process my medical claim. I also request that payment of government benefits, either to myself or to the party who accepts assignment.

Further, I authorize payment of medical benefits to be made directly to The Hearing Doctors, Inc. for services rendered. This authorization shall remain in effect until otherwise stated, in writing, by myself.

_____ _____/_____/_____

Patient/Parent/Guardian Signature Date

RELEASE OF MEDICAL INFORMATION

I, _____, hereby authorize The Hearing Doctors, Inc. to release any and all medical information in the course of my treatment to the primary care physician listed above. I would also like to have this information forwarded to:_____

_____ _____/_____/_____

Patient/Parent/Guardian Signature Date

The HEARING doctors

The Hearing Doctors, Inc.
311 S. County Farm Rd., Suite D
Wheaton, Illinois 60187-2477

tel: +1 630 752 9505 fax: +1 630 752 9626

Patient Authorization of Disclosure

In general, the HIPAA Privacy Rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. The patient may revoke or change this authorization at any time with a written request.

I wish to be contacted in the following manner (Check all that apply):

Home Telephone:

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

Work Telephone

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only
- ☐ Do not call me at work

Written Communication

- ☐ O.K. to mail to my home address
- ☐ O.K. to fax to my home fax:
- ☐ OTHER: _____

Patient Signature: _____ Date: _____

☐ Patient Refused to sign

In a further effort to protect your health information and the confidentiality of your healthcare, we ask that you designate below to whom the staff at The Hearing Doctors may discuss your healthcare and scheduling needs as well as billing issues that may arise.

Only disclose information to myself

Name_____ Relationship_____Phone_____

Name_____ Relationship_____Phone_____

Patient Signature:_____ Date:_____

Adult Case History Form

Patient Name:_____ **Age:**_____ **Date:**_____

1. Chief complaint: ❒ Hearing Loss (❒ Right ear/❒ Left ear) ❒ Tinnitus/Ringing ❒ Dizziness
❒ Difficulty hearing (❒ in Quiet ❒ in Noise) ❒ Telephone (❒ Right ear ❒ Left ear)

2. How long have you noticed this difficulty? _____

3. Is this problem due to a work-related injury/exposure? ❒ Yes ❒ No
If so: Date of Injury:_____ Explain:_____

4. Do you feel your hearing is changing? ❒ Yes ❒ No (❒ Gradual ❒ Sudden)

5. Have you ever been exposed to loud noise, either recently or in the past? ❒ Yes ❒ No
If so, please mark all that apply:
❒ Farm Machinery ❒ Music ❒ Hunting/Shooting ❒ Factory Noise
❒ Power Tools ❒ Military ❒ Jet Engines ❒ Other:_____

6. Have you seen an Ear, Nose and Throat Physician? ❒ Yes ❒ No
If so, who did you see?_____ When? _____

7. Have you ever had surgery that may have affected your hearing? ❒ Yes ❒ No

8. Is there a history of hearing loss in your family? ❒ Yes ❒ No If so, who?_____

9. Have you ever had an ear infection? ❒ Yes ❒ No (If yes, ❒ as a child ❒ as an adult)

10. Have you, in the past 10 years, experienced chronic or acute dizziness, lightheadedness, or vertigo?
❒ Yes ❒ No If yes, please describe: _____

11. Do you take any prescription medications on a regular basis? Please list:
Medication:_____ For:_____
Medication:_____ For:_____
Medication:_____ For:_____
Medication:_____ For:_____

12. Please check any of the following that you currently have or have had in the past:

❒ Arthritis	❒ Heart Trouble	❒ Measles	❒ Parkinson's
❒ Asthma	❒ Hepatitis	❒ Meningitis	❒ Scarlet Fever
❒ Bell's Palsy	❒ High Blood Pressure	❒ Mumps	❒ Sinusitis
❒ Diabetes	❒ HIV	❒ Neurological	❒ Stroke/TIA
❒ Head Injury	❒ Malaria	Symptoms	❒ Visual Trouble-Loss/Sight

13. Please rank the following in order of importance (1-4), if a hearing aid is recommended for you:
____ Improved hearing in quiet ____ Improved hearing in noise
____ Cosmetic appearance ____ Expense

14. If you are currently using a hearing aid, or have in the past, please answer the following:
Which ear is/was aided? ❒ Right ❒ Left
How long have you used a hearing aid? _____
What would improve your current hearing aid? _____